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ABSTRACT

Because of concern about the communication skills of dentists from countries of the European Economic Community wishing to practice in England, a project was undertaken to develop a pilot test of English language skills focusing on listening and speaking skills in dental practice contexts. This report consists of two proposals for developing pilot tests of foreign dentists' English skills in response to findings concerning the problems of dentist-patient communication in general practice and dental hospitals. The first proposal examines methods of devising a test sensitive to the language user's capacity to use appropriate skills in authentic contexts, specifying minimum prerequisites and limits for such a measure. The second proposal discusses the possibility of adapting a currently-used test for the medical profession, examines the issue of objectivity in testing communication skills, and suggests a period of induction into the British dental practice experience during which the foreign dentist would be assessed as well as oriented. (MSE)

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EVALUATING THE COMMUNICATIVE PROFICIENCY OF OVERSEAS DENTISTS

ANNEX TO GENERAL DENTAL COUNCIL REPORT

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Lancaster, October 1980.

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Lancaster October 1980

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Introduction

The original stimulus from the General Dental Council to undertake research into the nature of Dentist-Patient communication was linked to the possibility, ultimately, of making use of the results of such research for the development of pilot tests in English language for dentists from overseas, particularly from the EEC. Accordingly, in this Annex to the main General Dental Council Report on Dentist-Patient Communication, we include two speculative papers by the Project Assistants, Jill Burton and Rywal Coleman, suggesting alternative but integratable ways of devising such tests.

Both these papers have been able to draw on Lancaster experience in devising the language components of the Temporary Registration Assessment Board tests of the General Medical Council (now entitled the Professional and Linguistic Assessments Board), which have been administered regularly since June 1975.

The two proposals set out in this Annex reflect two possible views on potential solutions to the problem of devising tests which will address the demands posed by Dentist-Patient Communication, as analysed in the main Report.

1. Jill Burton's paper: Proposals for a Language Proficiency Test for Dentists from Overseas examines ways in which a test could be devised which would be sensitive to the language user's capacity (in this case, the dentist's) to use appropriate skills, in contexts which were authentic to those of actual use.

> "Any activity included in a language proficiency test for dentists from overseas must replicate the demands of the activity, otherwise the test will not be testing the candidate's linguistic ability in that typical dentist's task"

In making her proposals, Jill Burton not only sets out what are minimum prerequisites for the design and validation of an appropriate test, but, significantly, indicates the limits on any such test, however valid, in assessing the likely performance of a dentist from overseas in general or hospital practice in this country. It is of the utmost importance to realise the limitations of tests, in terms of predicting adequate or appropriate behaviour, particularly when one is undertaking any such 'prediction' on behalf of patients who are themselves, quite clearly, ignorant of technical dental expertise.

Nevertheless, her suggestions will be valuable, not least because she is at pains to describe in detail the procedures that would have to be followed, were any test to be established. The crucial question still remains, however:

> "how to decide what are adequate assessment criteria, and what is an adequate performance in relation to the criteria established?"

This is a question which is there for dentists, rather more than linguists, to answer.

2. Hywel Coleman's paper: Evaluating the Communicative Proficiency of Overseas Dentists begins by evaluating the present FLAB Test (see above) in the light of developments in test construction and our understanding of the rules governing communicative behaviour, in the five years since its introduction (as the TRAB Test) by the General Medical Council. He makes the point that, were its validity not in question on a number of crucial counts, such a test could be readily adapted to serve the needs of dentists rather than doctors, by making use of the data and analyses from the main General Dental Council Report. Part of the problem of validity depends on the length of time any incoming overseas dentist might be permitted to have before being assessed on his awareness of and competence in dentist-patient communication when measured against native-speaker norms, part upon the capacity of test designers to make 'objective' the integrated nature of human communicative behaviour. This latter issue is made more acute when one takes the point from the main Report that the rules governing dentist-patient communication are in some sense a product of compromise between dentist and patient as to what each regards as acceptable behaviour. Obviously similar questions to those posed by Jill Burton arise: what (for the purpose of any 'objective' test) is to be accounted acceptable behaviour? Who is to be the arbiter?

Hywel Coleman offers an ingenious solution, one, indeed, which was mooted for overseas doctors, though not accepted, at the time of the inception of the TRAB Test. The Communicative Proficiency Test for Dentists from Overseas, it is proposed, should be administered "while the

overseas dentist is experiencing a structured induction to life and dental practice in the United Kingdom, rather than on the moment he first arrives in Britain." This induction period would serve as a period during which the overseas dentist " a) is target b) observes, c) participates, d) is assessed." Hywel Coleman's paper concludes with an indication of how this induction process might be managed, and how during it the overseas dentist would be continuously assessed against a background of normal and contextualised dentist-patient communication.

Christopher N Candlin

I INDICATIONS FROM RESEARCH FOR TESTING

It appears that the dentist:

> is very much in control of the language and the activity in the dental encounter
>
> (Candlin, Burton and Coleman 1980)

and that the patients seem to

> expect this to be true, even those patients who are the type who expect to talk.
>
> (ibid)

Furthermore, the dentist by explaining to the patient what he is going to do and instructing the patient how to act, is, in fact, controlling the patient's reactions.

It seems in general that the dentist is able to manage the event, and to a certain extent, the behaviour of the patient, owing to his knowledge of the event, his expertise in the non-verbal activity of the event and the patient's expectation of his role in the event. The dentist uses strategies to communicate with his patients: they may be overt or covert.

It is these strategies of communication and organisation, which demonstrate the dentist's sensitivity to individual patients and which depend partly on an awareness of the patient's cultural and social background, that should be tested. It is not just dentists' linguistic behaviour that is important, but also how this is interwoven with

non-verbal activity, how appropriate the language is to the activity as well as for the patient personally. The dental encounter has been investigated from the patient's point of view, and the findings indicate the importance of the dentist's appropriate handling of the encounter for each patient. The dentist's sensitivity to patient need depends to a large extent on his perception of the patient through what the patient communicates about himself verbally and non-verbally, consciously or unconsciously. As far as language skills are concerned, this involves listening, and also eliciting relevant information that the patient may not otherwise have thought to provide. To encourage patients to volunteer appropriate information means that the dentist aims to set the patient at his ease so that the latter is willing and able to provide relevant information.

II AN APPROPRIATE THEORETICAL FRAMEWORK

If, as has been argued in the main Report, the information that interlocutors provide through their roles in a setting, their gestures, their tone of voice, their facial expressions etc., also provides

> instructions concerning the interpretation of factively coded information
>
> (Oller, 1979:27)

then these attidudinal aspects of communication must also be tested as well as the factive aspects. And if

> boundaries between linguistic segments are nearly perfectly synchronised with changes

> in bodily postures, gestures, tone of voice and the like
>
> (ibid: 24)

then it follows that both aspects, factive and attitudinal, should be tested together. A suitable test must assess the advance planning and hypothesizing that language users incorporate in their linguistic production, according to their perception of contextual constraints and their adaptation of their perceptions as the context changes, whether by their own manipulation or their perceptions of the manipulations of others, because communicative competence is

> the ability to function in a truly communicative setting - that is, in a dynamic exchange in which linguistic competence must adapt itself to the total informational output, both linguistic and paralinguistic, of one or more interlocutors.
>
> (Savignon, 1972:8)

Whereas discrete item tests divide language skills into parts, integrative tests aim at assessing a language user's capacity to use appropriate aspects of language skills together. Integrative tests provide an appropriate task which requires the candidate to

> process sequences of elements in a language that conform to the normal contextual constraints of that language.
>
> (Oller:38)

Thus to begin the process of devising a suitable language proficiency test for dentists from overseas, it is necessary to decide which central dentists' tasks require a significant amount of talking. Following that, a test can be developed to assess candidates' language proficiency in those tasks. If talking is central to the activity, it follows that to assess a candidate's linguistic skills in this task, will determine their proficiency at the task, for example at history-taking or dental-educating. Any activity included in a language proficiency test for dentists from overseas (LPTDO) must replicate the demands of the activity, otherwise the test will not be testing the candidate's linguistic ability in that typical dentist's task.

Language proficiency tests for dentists are an uncharted field at the moment. Although language proficiency tests have been devised in other E.S.P. fields such as commerce and technical subjects, the most relevant battery of tests for the G.D.C. project is likely to prove to be that devised for doctors from overseas which was begun in 1975. As one would expect, to safeguard the efficacy of the test, its contents have not been publicly disclosed. Nevertheless, it is clear from the plethora of training materials that are being produced for this test, that a certain amount is known concerning its structure and form.

From its inception, the Examination for Overseas Doctors was designed to test equally, medical and linguistic proficiency. The examination consisted of an oral interview, a taped section assessing various aspects of listening comprehension and a written paper. The questions were based on a language-functional analysis of doctor-patient communication skills carried out at the University

of Lancaster in 1974, and are mostly developed directly from the data collected. The examiners consist of medical and linguistic experts, communication between the two groups being of paramount importance for the oral examination, in which the candidate's display of medical acumen with a patient in a simulation will be made apparent through his linguistic ability to convey the appropriate information in a suitable way.

Part II: LPTDO: CONSIDERATIONS

I TRAINING

It may well be that in assessing what skills a dentist needs to have, it will be found that native-speaking dentists do not necessarily have these skills. This might lead to changes in the dental training courses' syllabuses in the U.K., with perhaps components having to be added on communication skills and social psychology. As far as non-native speakers are concerned, the training ramifications could be felt in their native countries or courses specifically for preparing candidates for the test might be instituted here in the U.K..

II POLITICS

It appears likely that owing to the provisions of the E.E.C., any procedure that prevents professionals from member countries practising in another member state, will be deemed to be illegal. If that is the case, the host country will have the responsibility of seeing that:

> the persons concerned acquire, in their interest and in that of their patients, the linguistic knowledge necessary to the exercise of their profession in the host country.
>
> (Article 20 (3), 1st Medical Directive, E.E.C.)

This would change completely the emphasis of any testing procedure on proficiency to an assessment procedure diagnosing the linguistic needs of a professional choosing to practise in a specific country.

III VALIDITY

The kind of test that needs to be developed is one that tests appropriate behaviour rather than linguistic display of dental knowledge so as to discriminate between those that can and those that cannot perform adequately in the dental encounter. In this case, a test that has content validity is of prime importance.

Analysis of the data already collected reveals some communicative areas that are of vital importance. But as yet there are no testing procedures which have been standardised, (or been capable of being standardised) and can handle the test items indicated by analysis of the data as being important. For example, the dentist may have to explain to a patient what is likely to happen to his teeth and gums if he does not change how he cleans his teeth. Such an item would be difficult for a test to handle. If the patient does not take up the import of the dentist's communication, whose fault is that? Did the dentist explain the situation adequately? Was the patient not paying attention because the message did not seem relevant

to his experience? Was the patient unable to pay attention due to apprehension? Or, did the patient choose to display ignorance? Did the patient choose not to listen before the dentist started talking? Does the dentist's performance have to be adequate for each and every patient or for 'good' patients only or for a pre-determined patient-type? Does the dentist's behaviour have to satisfy patient expectations and/or those of his peers or superiors in the dental profession? Who decides, for the purpose of a LPTDO, what will be deemed an adequate performance? And, how will that decision be made?

The involvement of dentists in the test construction and piloting is very important. Related issues that will need discussion include the differing constraints of practising in different kinds of practices, the individual nature of each dental encounter and then, whether these sorts of differences can be handled by a test. The collection of data and their analyses need to be supported by dentists' research into what makes a good dentist; which kinds of patients need which kinds of dentist; to what extent a 'good' dentist's performance is confirmed or reduced by a bad patient. In other words, what is a dentist, what should he do, and do native-speaking dentists behave as the LPTDO is likely to expect dentists from overseas to behave? The whole question of what an adequate dental performance is will need extensive research by the dental profession. The linguists' tasks, besides analysing language samples, will be to devise a test that tests what is required of it.

It should be possible to devise a LPTDO that has face, content and construct validity. To devise a LPTDO that has concurrent and predictive validity is a more taxing problem,

particularly as at present, there is no other similar test that the LPTDO proposed below, can be correlated with. But, at any rate, if the proposed LPTDO assesses candidates' proficiency in typical dental activities it will have face and content validity, and the kind of test proposed below (a communicative skills test) will have construct validity because it is developed from current theories of communicative competence.

Evidently the validity of a LPTDO will take time to establish. By this is meant that testable items must be tried, correlated and rated according to experts' judgements of what is and what is not desirable linguistic behaviour in a dentist. But, the experts (experienced dentists) may not previously have evaluated the appropriateness of dentists' behaviour from quite this angle; they may be inexperienced.

IV THE SOCIO-CULTURAL FACTOR

The criteria developed from experts' judgements of what is appropriate linguistic behaviour in dentists, will be based on what is appropriate linguistic behaviour for native-speaking dentists; and what is expected of them, should not necessarily be expected of non-native-speaking dentists, even by their patients. If the patient perceives that his dentist's first language is not English, his expectation of dentist behaviour may be different. It may be that behaviour that would be inappropriate in a native-speaking dentist, will not be thought odd in a dentist from overseas - providing that the dentist is still able to communicate his concern for the patient and his expertise at dental treatment.

V RELIABILITY

A behaviour-orientated test which sets candidates tasks to perform will raise problems for reliability. For one thing, each task will have inherent in it many variables and, therefore, how could one correlate and discriminate between, for instance, two different questions on the same activity, or two different candidates' performance on a question? For another, one candidate is unlikely to perform the task identically a second time. Furthermore, the examiner(s) participation in the testing event, is almost bound to affect his/their judgement of the candidate. However, in communicative situations, participants do evaluate messages and negotiate interpretations of them successfully, and as it is precisely this kind of activity that the proposals suggested below aim to test, then it is logical that the LPTDO should incorporate these factors. The examiner(s) will be interacting with the candidates and will know from firsthand experience whether the latter are successful communicators or not.

VI POTENTIAL v. PROFICIENCY

If two dentists being assessed are deemed to have performed equally well, are they both likely to perform equally well in practice? May not one dentist actually have more potential than the other? Is it possible to test potential at the same time as proficiency? For the purpose of the G.D.C., it must be assumed that the candidate will have demonstrated potential in his native country and that that potential will be extended in the U.K., provided that his language proficiency is sufficient to enable him to

practise adequately, and that the conditions of his practising abroad were not so different as to impede his efficient practising in the U.K..

VII THE 'GOOD' CANDIDATE

The 'good' candiate may be the kind of dentist who demonstrates flexibility and interest in trying out new techniques, or he may be the kind of dentist who has the stamina to treat large numbers of patients and the ingenuity to be innovative in restricting conditions. (He may even be the kind of person who performs well with 'real' patients, but badly in demanding, direct testing conditions). Which kind of person should the test look for? This question is outside the scope of this project and needs to be decided in consultation with the General Dental Council.

Part III: LPTDO: PROPOSALS

I INTRODUCTION

Developing a test, particularly one in a new area, is a necessarily lengthy business. All that can be indicated here are:

(1) an awareness of construction and validation problems

(2) suggestions concerning testable items

(3) how they might be tested in the light of other tests that have been developed

It was decided to divide the testing project between the two Research Assistants on the basis of testable areas rather than testable skills because recent research has found that

integrative tests which apportion test items according to language function and context rather than language skills are at least as effective as discrete point tests. Communication cannot really be broken down simply into listening and speaking components since one perceives the effect of what one has said in others' responses, and that perception itself requires one to listen and to watch.

II EXAMPLES OF TESTABLE LANGUAGE ITEMS: REASSURING THE PATIENT

Below is a list of typical dental utterances which are intended to help the patient relax during treatment. Some discussion of them is given below the table:

Table 1

NO.	UTTERANCE	COMMENT
R1	Can I just pop that on there a moment it's alright it won't bite you	joke/explain
R2	yes yes I'll do that for you got a whole bucket of it (injection material) here we have	joke: inspection giving
R3	... then you'll have a better chance of keeping (it) right on top of it but you you're gonna have teeth for a long time yet	joke
R4	I want to spray a horrible taste on your gum	joke

NO.	UTTERANCE	COMMENT
R5	P: ... are you going to give me new crowns or put these ones back on D: they probably won't be worth putting back on ...	frank
R6	normally they're quite easily .. I just don't want to give you an anaesthetic before the baby's come along you know	frank concern/ safeguard
R7	it's difficult to do it just the one way though isn't it	sympathise: difficulty of proper teeth-cleaning
R8	I don't want you to lose it I want you to keep it	concern
R9	looks like being a bit bright again doesn't it	distract: drilling
R10	and by the time I've done that you'll be well away on the upper jaw	predict/ reassure: injection-taka
R11	just take it easy today by tomorrow probably forget all about it	predict/ reassure
R12	you'll probably find that after the first six months of wearing it your gums have shrunk a little bit if you feel that the thing gets loose erm we can either adjust it or if it gets very loose ...	predict/ explain + offer help
R13	if you've any problems with it come back and see me	offer help

NO.	UTTERANCE	COMMENT
R14	you like a wee injection if we're going to potter about with fillings	mitigate
R15	you'll be aware of a little pressure that's all nothing to hurt you just pressure on the tooth we're just going to support your head at the same time	mitigate
R16	this is just cold paste I'm going to pop it in the top you breathe through your nose that's right now just let your lip relax that's fine it's not in for long	praise/ mitigate: impression-taking
R17	good that's one	praise
R18	but er maybe maybe maybe maybe I don' know you were a child then weren't you 12 yes probably we tend not to give injections to young children actually 'cos ...	tact about another dentist: reassure
R19	you've got some little fillings to do	mitigate
R20	little very very slight amount of staining that's all just a polishing and fillings required in 2 teeth up there they've gone a bit sticky but they're not very bad but I think they want to be extended and done now before they get any bigger	mitigate: diagnose
R21	well it's just the same as last time you weren't worried last time were you	familiarise

NO.	UTTERANCE	COMMENT
R22	mm nearly finished that's the worst over	worst-over
R23	what you're feeling is the that's perfectly normal	nothing-to-worry-about/ normal
R24	just close again I want to see	instruct/ explain
R25	now think first thing we do is make these numb for you 'cos we're going to ...	predict/ explain

The examples in Table 1 above indicate the range of utterances that can be interpretated as "reassures". Sometimes instructions are softened by the use of just, informal expressions such as potter about (for "work in your mouth"), or use of adjectives like wee, little, small, and phrases such as a bit, that's all. The language used to instruct the patient on how to behave and/or explain what is going to happen is often broken up into small segments and interwoven with the language at stressful moments such as when an injection is given (Extract 1 below and R16 above). Jokes are used and quite often the dentist pretends some action he is about to take is going to be terrible so that the patient can see he is joking and that it is not going to be too painful at all. Frequently the patient is praised, sympathised with or informed when "the worst is over". When the dentist is frank in his prognosis of a tooth it can indicate his concern for the patient, particularly if

his voice is modulated so that he speaks slowly, quietly and seriously as in R12. Patients will often perceive the dentist's concern through the tenor rather than through the content of his message. Much reassurance is given through explaining procedure so that the patient knows what to expect as in R12, 24 and 25 above.

The longer extracts given below are produced in full so that the following can be demonstrated, how:

1. injection-giving can be made less stressful for the patient;
2. a frank and full explanation and discussion can reassure a concerned patient;
3. probing questions may be necessary to extract a full explanation from a patient before reassurance can be given.

Extract 1

D: it's a bit nippy it'll tend to make your eye water

P: yeah (laugh)

D: better give you one on this side too I'm afraid
P: good / ah mm

D: and a little at the back makes you feel a bit like a pin-cushion hold on last one (got your denture down) okay

P: mm

D: that's the worst bit done ...

Extract 2

D: I'll simply clean that cyst out and the bone will heal up normally / okay
P: / oh my goodness

D: no it's not it's nothing to worry about it's much less than getting a tooth out

P: is it / it's just that you go to / sleep rather than have
D: / it's a fussy thing / well that's right because

P: (( ) and things
D: if you try to localise it the cyst has no blood supply so it can't get properly anaesthetised so I start to
P: oh I see yeah

D: poke about there you'd (much better) to see you again
P: yeah

D: you see and we couldn't have that so that we just do a
P: I see yeah no Idon't want

D: quick ( )
P: to be going to sleep now do I not near having the baby
D: no no
I wouldn't do it I I would leave it till afterwards and
P: I say after that then what I'll do whilst you're asleep
no

D: is I'll put the (nerve) out the tooth at the same time
P: and then go straight ahead and put a wee cap on it and
yeah

D: bob's your uncle but what I'll do just now I'll keep it
P: right for you whilst you're having the baby okay it's a
just keep it alright smashing
D: permanent job but we're only doing it temporarily while
P: yeah

D: we get the thing over and done with for you

P: alright

Extract 3

D: you didn't mention that last time did you

P: but I can do with just if it's just fillings I can get

D: d'you are you telling me that the fillings you've had
P: ( )

D: done were done while you were having an intravenous
P: anaes thetic
yes

D: were you ah that probably account for a lot of the problems doesn't it see the problem is that if you're gonna have erm a general anaesthetic there's always a hurry to get you conscious again

P: is there

D: yeah and that's why probably finishes up with having things not quite completed and things like that and I ain't gonna do that

P: no it's [alright then
D: [mm that's alright oh thank you very much

P: (I just thought) mention it you [know
D: [I see but why did you need anything in your arm y- you're not that scared are you

P: no

D: don't say no if you mean yes yes you mean you are

P: a little bit that's all

D: scared of what getting hurt

P: I don't know

D: well you've had an awful lot of treatment done

P: yeah

D: is that why you're scared [d'you know I mean usually
P: [( )

D: people are scared of things they don't know about there's not much that can happen to you that you don't know about

P: no

D: so why do you remain scared

P: I don't know

D: it's just one of those things is [it
P: [yeah

D: okay well don't worry about it I'll warn you before ...

Table 2 below gives examples of utterances which the observer did not believe could be reassuring for the patient, but the patients to whom these remarks were addressed were regular patients and did not appear to be any more distressed than the patients who received the utterances in Table 1.

This is further indication of the difficulties inherent in devising the LPTDO. Communicative strategies, which to an observer or assessor may appear poor, and perhaps, even non-existant, may be totally acceptable to the patient. It would be unjust to discriminate against dentists from overseas on the grounds of poor communicative skills when native-speaking dentists are no 'better'. The writers of the LPTDO and the examiners of the candidates will need to be very clear about what behaviour can be reasonably expected of candidates.

Table 2

NO.	UTTERANCE	COMMENT
R1 R2	and when I tell you to close just relax and close when I take the impressions you've just to relax	tell to relax
R3	P: I always seem to have had trouble with me bottom (teeth) you know D: yes you have P: the gums have always been {dark / always} D: been a bit soft and ...	frank/bald
R4 R5	good you're fine about 3 to do P: aa aah aah D: sshh sshh sh keep still that's it that was nothing much was it	reassure

In summary, it seems that the dentist has to be able to:

1. minimise stress for the patient by the use of tone, jokes, mitigating vocabulary;
2. explain situation clearly for patients so that they know what to expect and how to behave;
3. demonstrate appropriate concern and sympathy for a patient so that the patient is confident that the dentist will do what is best for the patient.

III WHAT IS TO BE EXAMINED

The main emphasis of a LPTDO will be on assessing the dentist's behaviour with patients. Our brief was to provide for the General Dental Council:

1. a descriptive statement on the nature of dentist communication in general practice;
2. a pilot English language assessment scheme for overseas dentists wishing to work as dentists in general practice in the U.K., focussing on listening and speaking skills.

Clearly the construction of such a test would involve dentists as well as linguists as mentioned above, and dentists are likely to look for evidence of a candidate's dental knowledge and technique. Clearly then decisions will have to be made concerning any division of marks between the two areas. If it is decided that language proficiency is more important, and for reasons given above, language proficiency may be all that legally can be assessed, then the examiners must give sufficient weight to candidates' language proficiency. All the tasks suggested below for a LPTDO, would need to be checked and discussed with experienced dentists concerning their authenticity. This emphasizes the need for close collaboration between dentists and linguists in designing a test which extends the candidate professionally

as well as testing his communicative skills.

IV HOW CANDIDATES MIGHT BE EXAMINED

(A) An Oral Examination

If candidates are to be examined on their choice and style of language and its appropriateness in given contexts, then clearly candidates should be confronted with a "real" situation. There are alternatives:

(1) if candidates from the E.E.C. cannot be prevented from practising in the U.K. and a test is therefore inappropriate, they could be given a probationary period, during which they could be assessed by experienced dentists who might advise dentists from overseas on how they could work at improving their relationships with patients;

(2) a major test component could be an oral examination.

This paper will work on the latter alternative in connection with communicative strategies of reassurance for the patient. The situation in Extract 2 above on p.16, is used here as a sample oral assessment situation in Table 3a. The candidate is handed a situation card as follows:

Table 3a

Patient:	female, 28 weeks pregnant
Realia:	an X-ray of left jaw a dental chart
Problem:	a cyst on left jaw bone 4 fillings 1 crown
Task:	(1) explain the situation to the patient frankly, at the same time removing any fears she may have about the extent and seriousness of the problem
	(2) decide on suitable treatment procedure

The situation in Extract 3 above pp. 16 - 17 provides a second sample oral assessment task in Table 3b:

Table 3b

Patient:	female
Realia:	a dental chart an X-ray set of the whole mouth
Problem:	16 fillings patient requests general anaesthetic
Task:	(1) find out why the patient wants a general anaesthetic for fillings (2) reassure the patient concerning injections (3) decide on suitable treatment procedure

Ideally three examiners would be present, and one examiner would act as the patient. One of the other examiners must be a language expert, and it would be preferable if the "patient" is also a language expert, who might be more adept at demanding a display of appropriate communicative skills from the candidate than a non-language expert.

The simulation would be the most important part of the oral examination and should come last after the candidate has been given the chance to assess the examiners in conversation and to "warm up" in less stressful and less direct displays of language proficiency. Consequently the following procedure is suggested in Table 4 on p. 22.-

The main difference between stages 2 and 3 is the greater flexibility of stage 2. By this it is meant that the examiner can draw the candidate out with leading questions and discuss alternative strategies. The candidate will perceive what kind of answers are expected of him, but at the

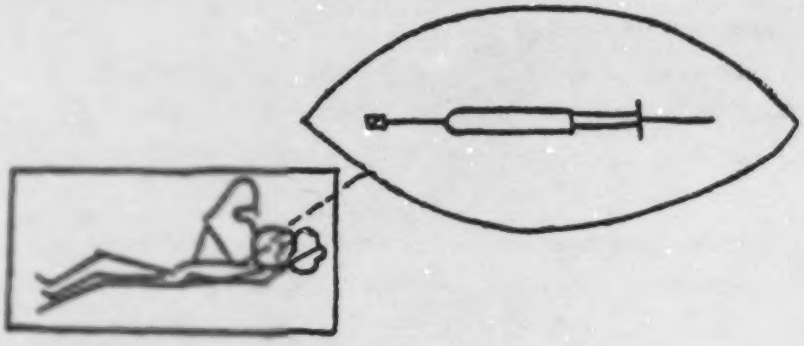
Table 4

ORAL EXAMINATION

Time: 45 minutes Examiners: 3

Stage 1: general conversation: introduced by examiner 1 to encourage candidate to talk by, for example, asking for details of previous dental experience, training, reasons for wishing to practise in the U.K. etc 5 mins

Stage 2: talk about pictures: 1-3 pictures, directed by examiner 2, on for example, the fitting of a denture, the giving of an injection (see below): 10 mins.



The giving of an injection:
2 injections are needed, explain to the patient in lay terms what you are going to do

Stage 3: dental simulation: see Tables 3a & b for examples, examiner 1 = patient, 2-3 situations 30 mins

OS

same time, the examiners will be able to assess the candidate's language proficiency and have some inkling as to what to expect of the candidate in stage 3. It is suggested that the "patient" in stage 3 should be the examiner who talks with the candidate in stage 1. The candidate will probably feel most relaxed with examiner 1 because this examiner spoke first and demanded less of the candidate. It is important that only one examiner should interact with the candidate at a time, thus leaving two examiners free to assess the candidate. One of the likely problems is different treatment for different candidates. This is hard to measure but it is quite possible that an examiner may help one candidate unduly by being more sympathetic, or by giving helpful hints. The emphasis on reducing examination stress for the candidate is wholly intentional; the examination aims to assess candidates' linguistic proficiency in as near to authentic conditions as can be reasonably expected. Accordingly examination stress should be minimised. Furthermore, the examination aims to assess "those who can" and "those who can't", and not to indicate "those who perform badly in a stressful examination task".

A five-point scale is suggested to assess the candidate's performance. The wording of the five proficiency levels should be as simple and concise as possible and for these reasons, the scales suggested below have been arranged as a series of questions to the examiners:

Table 5

A. THE CANDIDATE'S ABILITY TO MAKE HIMSELF UNDERSTOOD:

5 4 3 2 1

(Ring ♂ appropriate number)

(i) Is the candidate's pronunciation:

very easy to understand?	5
easy to understand?	4
fairly easy to understand?	3
difficult to understand?	2
very difficult to understand?	1

(ii) Is the candidate's intonation:

never inappropriate?	5
seldom inappropriate?	4
occasionally inappropriate	3
often inappropriate?	2
constantly inappropriate?	1

(iii) Is the candidate's choice of vocabulary:

perfectly suitable?	5
usually suitable?	4
sometimes suitable?	3
occasionally suitable?	2
very rarely suitable?	1

B. THE CANDIDATE'S ABILITY TO UNDERSTAND:

5 4 3 2 1

(Ring ♂ appropriate number)

The first category in Sections A and B is for the Examiners' overall impression of the candidate's ability. Section B has no sub-categories because assessment of the candidate's comprehension ability is difficult as it is

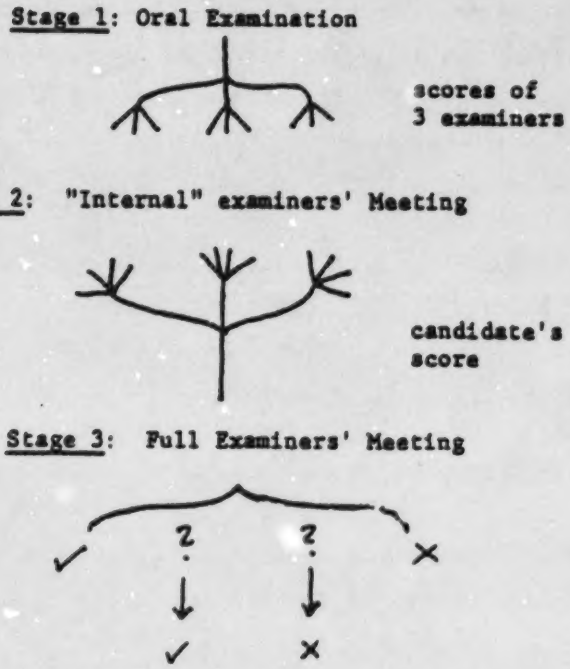
mainly observable in the candidate's responses. This is not to say that sub-categories assessing this ability cannot be devised, but that they need careful discussion. Possible sub-categories that could be included are: stress, intonation, purpose, understanding of idiomatic English. The first three categories are discussed in relation to a listening skills component below and the last category requires careful definition. The scales would be used at each stage of the oral examination.

It is recommended that the division of weighting be equal between each section, as interpretation and production are equally important communicative abilities. Within Section A, categories should be equally weighted. It may be advisable from later stages of test development to re-balance the assessment weighting, but for the initial stages it could be a confusion.

It is important that the subjective assessment which is involved in the use of rating scales be based on well-founded criteria concerning appropriate standards. This can only be attained following careful observation of dental practice, detailed discussion of standards to be followed, correlated with research into patient evaluation of treatment received and supported by a theoretical psycho-sociological framework. Examiners should complete an induction process into the particular nature of the assessment of the language proficiency skills of dentists from overseas, the criteria relevant to the LPTDO and take part in trial runs, before the test is administered. Use of a well-practised and carefully thought out series of scales could be shown to be reliable through correlation of different examiners' scores for the same candidate and an inquiry into whether the scales are difficult to operate or not.

It is recommended that initially any candidate with a 3 or above in a category should be deemed to have passed in that category. Candidates must pass the general impression categories of each section and at least one of the sub-categories in section A. Any candidate with two passes in the sub-categories of section A, a pass in the overall impression category in section A, and a 2 in section B should be discussed at a meeting of all the examiners. Any other candidatewith a similar borderline profile should also be discussed at a full examiner' meeting. Before this meeting, the three examiners of each candidate should agree on the candidate's score, although any marked dissent should be raised at the full examiners' meeting. The assessment sequence for each candidate therefore, will look something like this:

Table 6



It is suggested that as part of the examiners' induction/ practice period they should spend a minimum of two days observing student dentists (at varying levels of training and, therefore, competence) in dental teaching hospitals, ranking their performances and comparing scores with each other and the teaching staff.

It may be that there are only a few overseas dentists who wish to come and work in the U.K.. If this is the case, alternative 1, p 20 above should be employed. The candidate should be assessed "in situ" by an examiner according to the proficiency scales given in Table 5 above, without any obligation to grade pass candidates as 3,4 or 5, or fail candidates as 1 or 2: candidates could be given just a pass or fail with an examiner's report.

If funding or restricted numbers of candidates are to be important consideration, a restricted LPTDO might be considered consisting only of an oral examination as described above. For the purpose of this project, such considerations can be ignored. Since testing the language proficiency of dentists is an under-developed field (for the simple reason, that no such test has been required before) the problem of validity and correlation of the test remains. If a communicative abilities test can be administered that tests dentists' communicative abilities in recognised ways, then the tests proposed above could be correlated with it, assuming that "expert" judgements concerning the nature of appropriate communicative behaviour of dentists can be collected and refined. For these reasons, some suggestions for other test components are made below.

(B) A Written Component

Dentists have to write very little. In a general dental practice, patients' record cards are normally filled in by the assistant. In the dental hospital in which we observed and made audio-recordings the dentists did have to write lengthy notes for patients' files (mainly because the patients were not always seen by the same dentist twice) and draft letters of information or explanation to general dental practitioners who refer patients. This being the case, a written test may not be essential. How, as it can be argued that:

(1) an integrative test in the written form is testing communicative abilities in general and not, for example, writing as a language skill in particular, and

(2) some dentists from overseas may work in U.K. dental hospitals,

a written component may be desirable.

A cloze-type test was discarded, despite its likely flexibility , on the grounds that it does not involve the candidate in the kinds of tasks that are involved in dental practice, even though it may be argued that cloze tests test communication abilities in general.

Three sample questions are given below:

Table 7

WRITTEN EXAMINATION

1. Patient: male

   Problem: suspected gingivitis requiring surgical treatment

Task: Write a letter reffering this patient to the periodontic ward of x dental hospital. (Credit will be given for correct letter layout and appropriate English expression).

2. You have examined the patient and discovered that her condition is as shown on the chart :

Task: (a) write case notes to be put in the file

(b) describe what treatment you were able to give the patient in a 30-minute appointment.

(N.B. Your notes should be sufficiently clear for a dentist who has not seen the patient before to be able to understand the patient's condition and the treatment given so far, without seeing a dental chart).

3. Patient: female

Realia: case notes and dental chart

Problem: receding gums due to incorrent teeth-cleaning procedure

Task: Write to the patient's general dental practitioner to advise him of what treatment you will be able to give her and what treatment you expect him to give her.

(N.B. Be careful how you phrase the description of the treatment that you want the general dental practitioner to do).

Candidates should be asked to do two questions out of three in 30 minutes. It is possible that piloting of this component may indicate that 30 minutes is too long as dentists often perform these kinds of tasks very quickly. However, 30 minutes seems intuitively, to be a reasonable timespan to allow for satisfactory performance of the tasks. If, though, the test is to assess the performance of a task in hurried conditions, which may be the working conditions tha candidate will have to work in if successful, then 20 minutes could be a more reasonable timespan. It might be worthwhile to pilot this test on native-speakers giving different timespans to controlled groups to ascertain which timespan for the test is suitable. The range of questions from which the candidates choose will have to be carefully piloted so that there are not any questions that are obviously easier than others, and also to equalise the amount and variety of work entailed.

The paper should be double-marked, and triple-marked in cases of wide discrepancy. The markers should be language experts who should give impression marks on a scale of 5 to 1 as follows:

Table 8

A.	Appropriate Tone:	5 4 3 2 1
B.	Appropriate Phraseology:	5 4 3 2 1
C.	Grammar:	5 4 3 2 1
D.	Layout:	5 4 3 2 1
E.	Punctuation:	5 4 3 2 1

Candidates must get 3 or above in sections A and B, and in one other section. The paper should be marked "blind" with markers comparing assessments after marking a paper alone. Sections A and B will need further definition and possibly to be refined by appropriate sub-categories. Markers will be expected to do practice runs as for the Oral Examination above. Dental experts should be expected to check a proportion of the papers for appropriate dental knowledge. The subjective marking scales could be piloted against proven marking methods such as one mark off for every error - the error-types being pre-determined.

The case-notes sections of the examination are deliberately vague at present. They need to be refined in conjunction with dental experts' advice. For this project, choice of test format is deemed to be the more important issue.

(C) A Listening Skills Component

Although it can be reasonably argued that listening skills would be tested in the oral examination, two other possibilities are suggested:

(1) Audio-recording of dentist-patient interaction with examiner-led discussion of the communicative strategies employed by the dentist, as for example, in Extract 3 above. This component could be subsumed under the oral examination to make the latter a listening as well as oral production assessment, and be an alternative in Stage 2;

(2) An audio-taped multiple choice paper could be set with items that ask the candidates to decide on the purpose of an utterance. Examples are given in Table 9 below.

A cloze-type test was again discarded, as was a dictation, on the grounds that the kind of language used in these test-types is not the kind of language dentists hear. Conversation by definition cannot be predicted, and therefore, cloze tests and dictations would not test dentists in authentic listening activities.

Table 9

LISTENING SKILLS EXAMINATION

1. (Situation: drilling is about to be commenced):

   D → P: it looks like being a bit bright again, doesn't it

   The dentist is:

   (a) asking the patient a question to which he doesn't know the answer

   (b) commenting on the colour of something

   (c) attempting to distract the patient's attention from the treatment

   (d) interested generally in talking about the weather

2. (Situation: the dentist is giving the patient his diagnosis)

   D → P: You've got some little fillings to do

   The dentist is:

   (a) telling the patient what the patient has to do

   (b) commenting that the fillings the patient requires are few

   (c) reassuring the patient that the fillings required are small

   (d) telling the patients that the patient has quite a lot of fillings to be done

In sample 2, the answer is (d), which can only be known if the utterance is heard with the appropriate intonation and

stress. It seems unnecessary to devise separate listening comprehension components to assess, say, candidates' discrimination of intonation and stress separately from purpose because correct discrimination of stress and tone of utterances contribute together to the listener's ability to interpret the purpose or force of the speaker's utterance. The artificiality of the kind of component that is being suggested here is still apparent however, because in actual communication, the interpretation of an utterance can be negotiated between the speaker and the listener as they communicate with each other.

Returning to possibility (1), a more demanding listening skills component, which also involves production and negotiation, might be to require a candidate to:

Table 10

1. listen to a tape of a patient giving symptoms;
2. summarise what the patient has said;
3. comment on patient-type, if appropriate; for instance, sound a few notes of caution if the patient is likely to be difficult to deal with for any reason.

(D) A Reading Component

The only reading that a dentist has to do is to read brief referral letters from general dental practitioners and detailed case notes; both occur only in a dental hospital.

Candidates' reading skills could be tested by their being given a letter or case notes to read and summarise orally. the case notes should be hand written as this is likely to be a source of difficulty for overseas dentists. However, as the oral and written test components both require the candidate to read and digest case notes, and as his reading skill will be assessable through his oral and written responses, there would seem to be little justification for a separate component whose marking scheme and items would require separate validation.

V WEIGHTING OF THE COMPONENTS

The LPTDO recommended above would consist of two components: an oral examination (incorporating a listening skills section under Stage 2) of 45 minutes, and a written examination of possibly 20 or 30 minutes. Oral skills are more important for the dentist and therefore, the oral component should carry more weight (even though both components could be argued to be testing communication abilities). However it could prove more difficult to validate, although both components, as presently envisaged, involve subjective marking schemes. Therefore it is recommended that for a trial period of two pilot tests equal weighting should be given to both components.

VI CONCLUSIONS

The LPTDO recommended above aims to test the candidates' language proficiency in taks that are central to their practice of dentistry. However to make this test-type relaiable would involve lengthy research and piloting. The major problem with the LPTDO is its validation however:

> recent research has demonstrated that trained judges can render highly reliable evaluations of samples of speech acquired in oral interview settings.
>
> (Oller, 1979:392)

It is also indicated that:

> judges always seem to be evaluating communicative effectiveness regardless of whether they are trying to gauge 'fluency', 'accentedness','nativeness', 'grammar', 'vocabulary', 'content', 'comprehension' or whatever.
>
> (Calla way and Mullen, forthcoming)

It appears also that it is possible for examiners to agree over how subjects' performances should be ranked relative to each other, even if they disagree substantially on a particular score.

However, even if two candidates achieved the same score, this does not necessarily mean their performances were equivalent. The examiners' task appears to be to decide what the candidate meant to communicate, whether in writing or in speech, whether he communicated it well, whether he could have communicated it better, whether he was helped or hindered in his performance by the examiners and so on.

But the fundamental problem is still: how to decide what are adequate assessment criteria, and what is an adequate performance in relation to the criteria established? This is a relatively uncharted field, but one that needs to be researched. It is envisaged that piloting of tests based on the above kinds of premises will involve replication of test tasks in a range of appropriate dental contexts, that the test tasks must be carefully administered and controlled, and a wide range of

testable tasks should be trialled before the test field can be restricted to the kind of examination described above.

If overseas dentists are entitled to commence dental practice in the U.K. and if they can be required to start under some kind of supervision or advisory period, then concurrently patients should be asked to contribute reactions and opinions through questionnaires and structured interviews concerning their expectations of dental behaviour, both of native-speaking and non-native speaking dentists. Whatever test-type is finally advocated, it would be advisable to seek patient opinion because correlation with native-speaking dentists could not be satisfactory grounds for validation alone. We do not see as yet any other method of establishing reliability of test procedure or consistency of marking. It appears then that some type of posthoc validation is also advocated, on the intuitive grounds that the test-type proposed above will prove to be appropriate.

As an indication of the present state of the testing art, we cite the following:

> Subjectivity, implicit as it is in real-life communication situations, cannot with any validity be see as detrimental to the assessment of performance.
>
> (Rea, 1978:30)

Additionally, in view of current theories of language learning and teaching, and

> involving a consideration of the nature of language, we can conclude that any form of language test is valid if it presents the non-native speaker of English with language tasks that require him to process sequences of linguistic information reflecting the demands of actual speech events - thus activating what John Oller has called the "grammar of expectancy".
>
> (ibid:33)

These positive statements need to be treated with caution, but they indicate the present development of testing, in particular where the process of devising a test should start and in which direction it should go, even if the language tasks that communicators carry out cannot be analysed or assessed to any great degree of accurancy and delicacy. It would be a retrograde step, however, to avoid developing the LPTDO because its validation is unknown. If its validation were known to be impossible that would be a different matter.

Bibliography

Alderson, D & Ward, V., English Tests for Doctors, Nelson, 1979

Allen, J. P. B. & Corder, S. Pit, The Edinburgh Course in Applied Linguistics, Vol. 3: Techniques in Applied Linguistics, O.U.P., 1974

Burton, Jill I., The Dentist's Control of the Event in the Dental Surgery Through his Use of Language: Some Case Studies, Dissertation for M.A. in Linguistics for English Language Teaching, University of Lancaster, 1980

Callaway, D., & Mullen, K., "Accent and the Evaluation of ESL Oral Proficiency," in Oller, J. & Perkins, K., Research in Language Testing, U.S.A., Newbury House, forthcoming

Candlin, C. N. et al, Doctor-Patient Communication Skills: Working Papers 1 - 4, University of Lancaster, 1974

Candlin, C. N., Burton J & Coleman H., Dentist-Patient Communication - A Report to the General Dental Council Lancaster, 1980

Carroll, John B.,"Foreign Language Testing: Will the Persistant Problems Persist?" in M. ConCannon O'Brien, (Ed.), Proceedings of ATESOL, June, 1973, Dublin

Davies, Alan, Language Testing Symposium: A Psycho-linguistic Approach, O.U.P., 1968

Heaton, J. B., Writing English Language Tests, Longman, 1975

Jarvis, G. A., (Ed.), The ACTFL Review of Foreign Languages No 6, National Textbook Company, 1974
(a) Jorstad, Helen L., Testing as Communication
(b) Schulz, Renate A., & Bartz, Walter H., "Free to Communicate"

Jones, R. L., & Spolsky, R. (Eds.), Testing Language Proficiency, Arlington Va: Centre for Applied Linguistics, 1975
(a) Clark, John L. D., "Theoretical and Technical Considerations in Oral Proficiency Testing"
(b) Groot, Peter J., "Testing Communicative Competence in Listening Comprehension"
(c) Wilds, Claudia P., "The Oral Interview Test"

Levine, Harrold G. & McGuire, Christine H., "The Use of Role-Playing to Evaluate Affective Skills in Medicine," Journal of Medical Education, Vol. 45, September 1970

Oller, J. W., Jr., Language Tests at School: A Pragmatic Approach, Longman, U.K., 1979

Rasche, Lois M. et al, "Evaluation of a Systematic Approach to Teaching Interviewing, "Journal of Medical Education, Vol. 49, 1974

Rea, Pauline M., "Testing Doctors' Written Competence: An Experimental Technique in the Testing of Writing Proficiency in E.S.P.," University of Lancaster Linguistics Circle Paper, revised May, 1978

Savignon, Sandra J., Communicative Competence: An Experiment in Foreign-Language Teaching, Philadelphia: Centre for Curriculum Development, 1972

Scholtz, George E., & Celeste M., "Testing in an EFL/ESP Context," TESOL, 1979

University of Cambridge Local Examinations Syndicate:
Examinations in EFL: Specimen Papers
(a) English for Business
(b) English for Science

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1 INTRODUCTION

The University of Lancaster has been requested by the General Dental Council to provide a report on the nature of dentist- patient communication. At the time of writing four papers have been written on various aspects of communication between dentiscs and patients (Candlin, Burton and Coleman, 1980). The General Dental Council has also commissioned a preliminary description of the form which a language proficiency test for dentists who are nationals of member states of the E.E.C. might take. From the start, it has been assumed that the findings of the research into dentist-patient communication will serve as an instrument by which validity of test proposals may be measured.

The present paper assesses an earlier language proficiency test designed for a somewhat similar audience and argues that novelty and apparently revolutionary design are merely superficial. The paper then considers the problem of testability and goes on to suggest how the dichotomy between discrete point and pragmatic integrative tests might be bridged. Next, one or two very specific features of the dentist's communication repertoire and some of the problems associated with the testing of these features are discussed. Previous work on simulation, role play and self-assessment, particularly in the field of medical education, is described. Finally, an integrated programme for overseas dentists is proposed which would aim at developing dentists' sensitivity towards communicative techniques and, at the same time, would allow continuous assessment of their actual performance.

2 THE 'PLAB' TEST

An immediately obvious model for any test of the linguistic proficiency of overseas dentists lies in the PLAB Test. From its introduction in June 1975 until the end of 1978 the test was administered by the Temporary Registration Assessment Board of the General Medical Council of Great Britain (TRAB), which, in January 1979, became the Professional and Linguistic Assessments Board (PLAB).

Since 15 February 1979 the General Medical Council has had discretion to grant limited registration to overseas-qualified doctors who have been offered employment as medical practitioners in the United Kingdom or the Isle of Man. The Council does not, however, grant registration for the first time unless applicants have been successful in or have been exempted from the test administered by the Professional and Linguistic Assessments Board. This board is administered by the three non-university Licensing Bodies in the United Kingdom and has the specific objective of devising and conducting tests of proficiency in the English language and of professional knowledge and competence of doctors who obtained their qualifications from overseas. PLAB undertakes this work on behalf of the General Medical Council (Professional and Linguistic Assessments Board 1980; p 1).

Considerable dismay was aroused by the introduction of the test. This concern could be attributed partly to the fact of a test's having been introduced at all, partly to the adverse publicity for overseas-qualified doctors which the introduction of the test attracted, and partly (and by no means insignificantly) to the format and contents of the test. Thus, a paper issued by the Community Relations Commission in June 1976, just twelve

months after the TRAB test was first administered, commented (Reference and Community Services 1976) :

> There are three main issues which need further discussion in the new examination system. The first is that of the timing of the TRAB tests. The second is that of preparation for the tests. The third is that of the tests' content.
>
> (p 24)

With regard to timing and preparation, the Overseas Doctors' Association had proposed firstly that doctors should be allowed to take the test at the end of a three month clinical attachment, rather than immediately on arrival in the United Kingdom, and secondly that during this initial three month period the overseas-qualified doctors should have access to language training and to clinical ward rounds. Otherwise, the document comments :

> Given the absence of any formal preparation or training period this puts them at a considerable disadvantage. They have not had time to get accustomed to the way of life here and its effect on medical practice, the accents, local customs, superstitions, etc., that are peculiar to this country. They are therefore taking the test in a vacuum - unaware of what is expected of them from the examiners.
>
> (ibid.; p 24)

With regard to content, the validity of the test was questioned :

> There is some disagreement on whether understanding of the essentially complicated combination of colloquial language, presentation of symptoms and further questioning during a medical 'consultation' can be adequately assessed by that part of the test which seeks to examine a doctor's ability to understand a tape-recorded question out of its context. It could be that one of the causes of the low success rates in the TRAB tests is the difficulty of answering questions out of context, increased by insufficient preparation time and unfamiliarity with the country and its customs. . . . Understanding of basic, everyday English usage can best come from a combination of familiarity with spoken English and specific training.
>
> (ibid.; pp 24f)

In summary, the validity of the test was questioned on two grounds. Firstly, it was argued that responses to a tape-recorded, context-less question did not provide an adequate basis on which behaviour in a real medical consultation could be assessed. Secondly, it was suggested that the test could not realistically be expected to measure the degree of adaptation or cultural awareness of the examinees, when the majority of candidates have only recently arrived in Britain and therefore, by definition, are at the nadir of cultural incompetence.

From a different perspective - that of teachers concerned with improving the English of non-native-speaker doctors - the response to the introduction of the TRAB test was somewhat different. Alderson and Ward (1979b) describe the consternation which the new test caused in the English teaching world :

> To those of us involved in teaching English to overseas doctors . . . the introduction of the TRAB (now PLAB) test in the summer of 1975 came as something of a shock. Almost overnight our students, intelligent and highly-motivated, now became somewhat tense as they realised that their plans for post-graduate study, or work in the NHS, depended on their passing an exam which contained a linguistic as well as a medicalcomponent. They requested pre-test material which we, with the best will in the world, were not initially able to give them.
>
> (ibid.; p 4)

Alderson and Ward indicate (passim) that, although they have recovered from the initial shock, they still consider the test inadequate in several respects. The following quotations are illustrative of this dissatisfaction. Of the taped part of the test they say :

> Certainly the problems of accurate auditory comprehension and recall are compounded when one is listening to a foreign language against the clock.
>
> (ibid.; p 4)

(But when, in the casualty department of a hospital, is a doctor not 'listening against the clock'?)

Of a section in which appropriate responses to patient comments are to be selected:

> Distractors and idioms confound the candidate further. Doctors are always concerned with who is speaking to whom. Is it a doctor? Is it a patient? Is it a relative, colleague or layman? Since no information is given, it must be assumed that it is irrelevant . . .
> (ibid.; p 5)

On a section in which the speaker's mood is to be assessed :

> The moods to which a human being can be subject are many and varied, and the words to describe them are even more numerous. . . . In conversation, moods can be indicated by facial expression. On tape, however, the listener has to rely on supra segmentals.
> (p 6)

On the composition section of the written paper :

> Many doctors are accustomed to writing essays in English, although their core vocabulary is specialised and the distribution and content of words belong more to the field of medicine than to general English. However, in the course leading to PLAB, they must organise their thoughts and find something intelligent to say about a wide variety of subject headings that appear sometimes to have little direct relevance to their specialised professional concerns.
> (p 8)

A very considerable degree of initial consternation - particularly in the ELT world - may of course be a salutary side effect when a new test is introduced. But critisims of the test's validity must be considered very carefully. We will proceed by looking at how a language test for dentists, presented in the same format as the PLAB Test, would look.

The complete test consists of a language component and a professional component. Both components are sub-divided into three sections. The language component has a taped comprehension of spoken English section, a modified essay (written English) question, and a viva, whilst the professional component has a multiple choice question paper, a medical short answer paper, and a viva. A breakdown of the test's six sections is as follows :

1 LANGUAGE

a Taped comprehension of spoken English section

i to select a suitable reply to a spoken sentence

ii to decide the purpose of a spoken sentence

iii to distinguish the mood in which a sentence is spoken

iv to recognise the purpose of stressing a word in spoken English

b Modified essay (written English) section

i to write from 300 to 500 words on a general medical topic

ii to write from 200 to 300 words on a medical topic as though it were being addressed to a lay person

iii a cloze test

c Viva (combined with section 2.c. below)

2 PROFESSIONAL

a Multiple choice question paper (60 questions)

i c 25% surgery

ii c 25% obstetrics and gynaecology

iii c 50% medicine (including community medicine, dermatology, paediatrics and psychiatry)

b Medical short answer paper

to test ability to apply professional knowledge to a variety of clinical situations

c Viva (combined with section 1.c. above).

The test's format, approximate level of difficulty and type of content material are by now reasonably well know (cf Alderson and Ward 1979a). It

would not be too difficult to envisage an exactly parallel test for dentists. An indication of the form that questions in Sections 1.a. and 1.b. of a hypothetical PLAB Test for dentists might take is given here.

Section 1.a.i. : to select a suitable reply to a spoken sentence

(dentist's response to patient's prompt)

1) My gums are all red and sore

a Was it? When did that happen?

b Perhaps you've been using too much lipstick.

*c Whereabouts? Let me have a look.

d I read and saw that one too.

2) I think the filling's come out

*a Were you eating at the time?

b I haven't seen it anywhere.

c You mean, you can express your feelings now?

d When will they do that?

(patient's response to dentist's prompt)

1) Is it keeping you awake at night?

a That's no business of yours.

b No, I don't work nights.

c I expect it will next week.

*d Well not at first, but it is doing now.

2) How does it feel when I tap this one?

*a A bit sore.

b I think we should turn the tap off.

c I don't know how she feels.

d You're quite right.

Section 1.a.ii. : to decide the purpose of a spoken sentence

(patient's interpretation of dentist's prompt)

1) You say you've been having this problem for six months now.

a Coming to a conclusion

b Making a statement

c Giving a diagnosis

*d Seeking confirmation

2) Well it's just one small filling we're doing today, isn't it?

a Seeking information

b Giving advice

*c Reiterating treatment programme

d Seeking permission

(dentist's interpretation of patient's prompt)

1) You're sure there's nothing wrong with my mouth?

a Making a statement

b Criticising the dentist

*c Seeking reassurance

d Showing indifference

2) Is it er possible that you could erm also clean them a bit?

*a Requesting treatment

b Making an invitation

c Expressing disapproval

d Questioning the dentist's capabilities

Section 1.a.iii. : to distinguish the mood in which a sentence is spoken

(patient's assessment of dentist's mood)

1) Well you really will have to try a bit better than this.

a Satisfied

*b Irritated

c Sympathetic

d Joyful

2) Oh dear dear dear that does look sore, doesn't it?

a Modest

b Exhausted

*c Concerned

d Shy

(dentist's assessment of patient's mood)

1) I'm so glad you won't have to take it out.

a Worried

b Optimistic

c Impetuous

*d Relieved

2) It'll have to come out, I suppose, will it?

a Nervous

b Bewildered

c Jocular

*d Resigned

Section 1.a.iv. : to recognise the purpose of stressing a word in spoken English

(patient's interpretation of stress in dentist's speech)

1) You wouldn't be needing a new set of dentures now if you'd kept the old set in <u>all</u> the time.

a You'd be using them.

b But your wife would be needing a new set.

*c Instead of wearing them only occasionally.

d Though you might have needed new crowns.

2) Well I can't do this for you <u>today</u>, I'm afraid.

a But I can do it for your daughter, if you like.

*b But you can make an appointment for next week.

c But my associate will be able to do it for you.

d But I can do the scaling and polishing for you.

(dentist's interpretation of stress in patient's speech)

1) <u>This</u> one's been fine since I last saw you.

*a But the tooth next to it hurts badly.

b So I don't have any problems now.

c But it was hurting before my last appointment.

d But I had a lot of trouble with it when I was seeing Mr Smith.

2) Will you <u>have</u> to make it numb before you do that?

a Can't your assistant do it for you?

b Couldn't you just polish it?

c Can't you leave it until later?

*d Couldn't you do it without an injection?

Section 1.b.i. : to write from 300 to 500 words on a general dental topic;

choose one of the following three topics :

1 Arguments for and against the extraction of teeth.

2 The dentist's role in dental health education.

3 Fluoridation of drinking water.

Section 1.b.ii. : to write from 200 to 300 words on a dental topic as though it were being addressed to a lay person;

choose one of the following two topics :

A new patient, a young man with an apparently limited educational background, comes to you with extensive dental caries. You realise that treatment will be a lengthy process but you are worried that the patient may soon lose interest in the treatment programme. Write down exactly what you would say to the patient to convince him that he must attend regularly.

Your patient, an elderly lady, is complaining of problems with her new set of dentures. This is the fourth set you have made for her in the last seven years and you suspect that the patient does not wear her dentures regularly. What exactly would you say to the patient to persuade her to wear her dentures all the time?

Section 1.b.iii.: cloze test

insert single words in the gaps left in the following prose passage. The words must be grammatically correct and must make good sense.

The dentist is discussing the treatment programme with a continuing patient who has just entered the surgery. He says, "Today I am going ___(1)___ remove those two fillings ___(2)___ you. That is what we planned, ___(3)___ it not? One of them is up ___(4)___ the top near the back, ___(5)___ the other one is down ___(6)___ at the front. Then we ___(7)___ see what the state of ___(8)___ two teeth is. You may ___(9)___ to lose one or both ___(10)___ them when we have removed ___(11)___ amalgam. But at the moment

__(12)__ do not know what is __(13)__ . However we will do everything __(14)__ can to save them for you."

1	to	8	the
2	for	9	have
3	is	10	of
4	at	11	the
5	and	12	we
6	here	13	underneath
7	will	14	we

It may now be clear that the construction of test items of this sort is not an overly difficult task. The stimulus sentences of Sections 1.a.i. to 1.a.iv., and the monologue of Section 1.b.iii. are all taken directly from actual data, whilst real situtation similar to those described in Section 1.b.ii. have been observed during the data collecting stage of the project. (Nevertheless, evaluation of the validity of each individual item would still have to be performed in the normal way.)

But perhaps this relative lack of difficulty in preparing test items should give us pause for thought. Face validity of the questions (of Lado 1961, pp 321f; Davies 1977, p 60) appears to be acceptable. The overall test format has been tried, improved and used intensively over a five year period. And yet, there are some fundamental questions concerning the nature of the communicative process and the function of a communicative test which a test such as that outlined above fails to come to grips with. An attempt is made in the following section to - at least - delineate these problems, even though there may as yet be no solutions to them.

3 HOW TO TEST?

Conventionally, language testing has been concerned with discrete points of phonology, lexis or syntax which are examined extra-contextually although in relation to the four skills of reading, writing, speaking and listening. However, Oller (1979) comments :

> The premise of discrete point theories, that language can be taken to pieces and put together in the curriculum, is apparently false. Any discourse in any natural language is more than the mere sum of its analyzable parts. Crucial properties of language are lost when it is broken down into discrete phonemic contrasts, words, structures and the like. Nonsense, of the sort recommended by some experts as a basis for discrete point test items, does not exhibit many of the pragmatic properties of normal sensible utterances in discourse contexts. The trouble is that the lowest level units of discourse are involved in the production and interpretation of the highest level units. They cannot, therefore, be separated without obliterating the characteristic relationships between them.
> (p 229)

More recently, pragmatic integrative tests have developed in reaction to the artificiality of discrete point tests. Oller (ibid.) defines integrative tests as "antithetical to discrete point tests. Integrative tests lump many elements and possibly several components, aspects and skills together and test them all at the same time" (p 70). Pragmatic tests, which form a special class of integrative test, must meet two naturalness criteria : "first, they must require the learner to utilize normal contextual constraints on sequences in the language; and, second, they must require comprehension (and possibly production also) of meaningful sequences of elements in the language in relation to extralinguistic contexts" (p 70). Therefore, Oller concludes, discrete point tests cannot be pragmatic tests.

The theoretical distinction between 'traditional' discrete point tests and 'contemporary' pragmatic integrative tests lies in the factors of analysis and context. Discrete point tests analyze language and abstract items from

context; pragmatic tests reject analysis and pay primary attention to context. In practice, however, this dichotomy may not be so easily distinguishable. For example, a test which, by its very title, declares its affiliation is the Integrative Grammar Test (Bowen 1976, 1977). It is claimed not only that the IGT can test the ability of subjects to "reconstruct and identify the normal allegro forms of the meanings and constructions of informal, conversational English" but also that it "clearly separates native and non-native speakers of English" (Bowen 1976; p 37). However, it has been shown (Coleman 1977) that, not suprisingly, the IGT fails to measure native speaker competence in toto in such a way that it can be distinguished from non-native speaker competence. What the IGT actually does is to test the ability of subjects to reconstruct and identify the reductions, contractions and assimilations of informal spoken English; that is, it indicates to what extent the subject is aware of the formal (expanded) basis of colloquial (contracted) English. In other words, the IGT is basically a discrete point test which, because of its unusual format and the uncommon point which it discretely tests, calls itself an integrative test. '(On the question of distinguishing between native speaker and non-native speaker competence, see Alderson 1980.)'

Let us consider now the PLAB Test in the light of the debate between discrete point and pragmatic integrative testing. It was observed in Section 2 above that, almost from the moment when the test was first introduced in 1975, the Overseas Doctors Association questioned the validity of using checklist type responses to disembodied audio-recordings as an indicator of competence to deal with an 'essentially complicated' medical consultation. This is a powerful criticism and one to which no adequate reply is available in the literature. A somewhat similar criticism with regard to the modified essay question is made below.

Sections 1.a.ii. to 1.a.iv. test the subject's ability to interpret, respectively, speaker's general purpose, speaker's mood, and speaker's purpose in stressing particular items. Thus these sections of the PLAB Test - very much like the IGT - are actually discrete point tests which are testing novel aspects of language (speaker's mood, purpose, etc.) instead of more conventional aspects (syntax, phonology). The uniqueness of the discrete points which are being tested does not, however, grant the test immunity to the criticism which applies to all discrete point tests, that breaking down language into fractions obliterates the 'characteristic relationships' between these fractions.

Furthermore, any test of any discrete point must beg the question, "Why <u>this</u> point?" Why is a test of ability to recognize speaker's mood (something, incidentally, which can frequently be done without knowing anything of the language being spoken) <u>more</u> important for a doctor than a test of ability to recognize appropriate syntactic structures? Why is an ability to make phonological distinctions <u>less</u> important for a doctor than an ability to make distinctions based on stress? Until it can be demonstrated that these skills can be ordered hierarchically (something which yet remains to be done) it must be assumed that they are all of <u>equal</u> importance.

It has been argued that component 1.a. of the PLAB Test, though novel and imaginative, is not necessarily any less subject to objections of questionable validity than any other discrete point test. What of component 1.b., the modified essay (written English) section? Pauline Rea (1978) attempts to answer this question in the following way :

> Requesting examinees to write down what they would actually <u>SAY</u> in a given situation is an artificial construct for

testing purposes and clearly lacking in face validity.
(p 13)

However:

> It can be claimed that (the modified essay question) assesses a representative sample of the target language, testing many of the observed and frequently occurring behaviours in a clinical setting. The (modified essay question) sets out to assess the use of several codes of the language in those areas in which a doctor needs to be proficient. Therefore . . . this testing device can be said to have high content validity.
> (p 32)

In direct conflict with the original acknowledgement that the test is "clearly lacking in face validity", Rea later adds:

> To the extent that the (modified essay question) can be seen as a measure assessing the appropriate levels of language and language skills within the specified context it can claim face validity.
> (p 32)

Can face validity be claimed simply by virtue of the fact that a test assesses language and language skills "within the specified context"? A test which takes as its subject matter a clinical problem does not therefore and automatically become a valid one. In the same way, a written passage which deals with a technical subject does not therefore and automatically become an appropriate ESP text, since matters such as the register in which the passage is written and the audience for whom it is intended must also be taken into consideration.

But beyond this, it is notoriously difficult to analysethe stages and make a verbal description (whether spoken or written) of one's own routine behaviour when performing relatively complicated tasks - walking, for example, or riding a bicycle. Yet experiencing difficulty in talking about how one would ride a bike in certain specified circumstances is obviously not an indication of inability to actually ride a bicycle in those circumstances. The same must be true of talking about how one would talk to a patient in certain specified circumstances. The fact that the peculiar nature of the behaviour being described therefore makes the task demanded by the test into a metalinguistic

one does not imply that the examination task is any easier than when it involves description of non-linguistic behaviour. Indeed there is very good reason to believe that interaction with another human being is, relatively, considerably more complicated than walking or riding a bicycle. If this is the case then, ipso facto, describing interaction must be even more complicated than describing the actions of walking or cycling. That is to say, it is difficult to accept that inadequacy in describing how one would interact with a certain patient in a given situation (however that inadequacy be judged) can be a valid indicator of inadequacy in actually interacting with that patient in that situation (however that inadequacy be judged).

At this point, let us return to Oller's contention, quoted earlier, that discrete point tests cannot be pragmatic tests and consider the acceptability of this statement. In order to 'do testing', the tester must know what is correct, acceptable or appropriate. Not only that, but he must also know what is incorrect, unacceptable or inappropriate. Furthermore he must know why what is incorrect (etc.) is considered so. In other words, the tester must have criteria by which he judges the acceptability or otherwise of the answers which his subjects give him. Much is now known about certain aspects of certain languages so that highly detailed and very complex descriptions of those areas of those languages can be made. There is, for example, a wealth of detail available concerning the syntax and phonology of English. With these data, a test designer has no difficulty in establishing what is correct, acceptable or appropriate and what is incorrect, unacceptable or inappropriate. These data and this facility in determining what is correct are the basic requirements of a discrete point test. Only when precise data of this sort are available can the process which leads to the production of an objective test be begun.

We have suggested that only certain aspects of certain languages can, as yet, be tested 'objectively' using a discrete point technique. (We are now, for the moment, putting aside the question of the desirability or otherwise of tests of this type.) There are, however, other aspects of even the most exhaustively described languages about which little is yet known. Relatively little is yet understood, for example, about the ways in which language is actually employed as a communicative instrument, and how these ways may vary as the context changes. It is possible for the native speaker to 'feel' subjectively what is correct, but it is not yet possible to make the same sort of objective judgment about what is incorrect as can be made about more accessible aspects of the language such as syntax, nor is it possible to establish why what is communicatively correct is so. That is, there exist no criteria for judging the appropriacy or otherwise of particular instances of language use which parallel the criteria for judging the acceptability or otherwise of syntactic forms. In this case, subjective judgments must be made. Consequently testing in its traditional objective quantifiable sense becomes - if not impossible - then at the very least extremely difficult.

These observations are not in any way surprising, of course. The truth behind them is well understood. The situation, then, seems to be that approaches to testing have polarised :

type	conventional	contemporary
technique	discrete point	pragmatic integrative
evaluation	objective	subjective
features tested	well-understood : syntax, etc.	poorly-understood : communicative use, etc.

Test designers who are concerned to incorporate poorly-understood features of language in their tests have apparently accepted unquestioningly that these features cannot be tested objectively using discrete point techniques but must inevitably be tested subjectively using pragmatic integrative techniques. Thus Rea (op. cit.), for example, argues that subjective evaluation is not necessarily 'evil' :

> I can see no justification whatsoever in regarding the testing situation as a special case and for viewing subjective judgments as something harmful. Subjectivity implicit as it is in real life communication situations cannot with any validity be seen as detrimental to the assessment of language performance.
>
> (p 30)

However, we prefer to believe that the objectivity possible in discrete point tests and the subjectivity necessary in pragmatic integrative tests are not corollaries either of the testing techniques employed or of the language features being tested. They are, rather, associated with the present state of our knowledge of those language features. That is to say, enough is known about, for example, the syntax of English for discrete point tests of syntactic features to be developed; enough is known to allow objective assessments of the appropriacy or otherwise of particular structures to be made. But, on the other hand, so little is known about, for example, the communicative use of English that subjective assessments of the appropriacy or otherwise of particular communicative acts have to be made. In turn, this need has become almost inextricably associated with the concept of pragmatic (contextualised) integrative (non-discrete) tests.

It is proposed that the sole distinguishing feature which has induced this polarisation is the extent or paucity of our present knowledge of the features being tested. If more were known about, say, how language is used communicatively, then it is not inconceivable that a subject's mastery of

communicative language use could be tested using discete point techniques. Such a test would, though, necessarily be pragmatic (i.e. contextualised) since it would be concerned with the subject's ability to use language appropraitely in context. This test, however, would not be integrative (i e. non-discrete). Our arguement then is that as our understanding of certain aspects of the language becomes more complete so these aspects - and the pragmatic testing techniques associated with them - will shift across from the right-hand list in the table on page 22, to the left-hand list. The consequences will be that a) a pragmatic discrete point test of communicative ability will become feasible; b) pragmatic tests need not be a type only of integrative tests; c) objective assessments of communicative competence will become possible.

In summary, it is perhaps valuable to see this shifting from right-hand column to left in the table above as an ongoing historical process. To see this polarisation as rigid and unchanging is defeatist. Objectivity, in so far as it indicates absolute impartiality, is an ideal (though perhaps unattainable) aim, whilst subjectivity, in so far as it allows the possibility of partiality, can be no more than an occasional expedient. The degree to which discrete point techniques can be employed when any feature of the language is being tested is directly related to the amount that is known about that feature. Communicative features of language must be tested pragmatically, but like any other features of language they can be tested integratively or discretely. Discrete point techniques, however, allow greater objectivity in evaluating performance.

4 RULES OF DENTIST-PATIENT DISCOURSE

In the preceding section it was suggested that, ultimately, a pragmatic discret point test of communicative competence might be feasible. In this section we will look at aspects of the discourses which occurs between dentists and their patients, in the hope of discovering features which might lend themselves to testing in this way.

The opportunities given by dentists to dental patients to describe their own symptoms, the ways in which patients descibre their symptoms, and the ways in which dentists react to patients' reports of their symptoms have been investigated (Candlin, Burton and Coleman 1980). The findings of this investigation are summarised briefly here.

Consultations fall into two main categories: 'patient initiated' (in which patient-knows-all and dentist-knows-nothing when the consultation commences) and 'continuing treatment' (in which dentist-knows-all and patient-knows-next-to-nothing when the consultation commences). There are other types of consultation which fall at various points along a continuum between these two extremes.

Patient initiated consultations may open in one of two ways: either the patient, without prompting, goes immediately into a report of his complaint, or the dentists at a very early stage invites the patient to make a report ("What brings you here today?"). Whichever commencing style occurs, however, the manner in which the patient eventually makes his report is characteristically indirect. This indirectness may be manifested in one of

several ways. The patient may simply describe a certain course of treatment (which, it later turns out, was effective when previously employed to treat symptoms similar to those which the patient is experiencing now). Or the patient may simply describe apprehensions or affective reactions (though the symptoms which inspired these apprehensions or reactions may go unstated). Or the patient may describe a recent event which has taken place in his mouth (e.g. a filling has crumbled, although it may be that the pain which the patient is experiencing - but which he does not mention - is not actually caused by a crumbling filling).

Continuing consultations are quite different. In these the dentist knows precisely why the patient is attending for treatment and precisely what treatment is to be administered. The patient, on the other hand, may be almost totally ignorant of what treatment is to be performed upon him. In consultations of this type the patient is never given an open-ended invitation to describe any new symptons which he may be experiencing (at least not in the corpus of data available for this research). Many consultations commence with the dentist instructing the patient to "sit down and open wide", or with a brief description of the session's treatment programme. Occasionally the dentist makes a specific enquiry concerning the treatment which the patient received in the most recent preceding consultation, but during none of the observed consultations does the dentist provide the patient with a clear opportunity to discuss <u>new</u> symptoms. In this case, the patient who has a new complaint which he wishes to bring to the attention of his dentist is obliged to seize an opportunity, since he is unlikely ever to be granted one. Patients seize opportunities either by extending the scope of specific enquiries from their dentists (and thus apparently misunderstanding those enquiries) or by introducing discussion of their new symptoms at arbitrary points throughout

the consultation, apropos of nothing. When a patient seizes an opportunity to report a new complaint his report - unlike the indirect one he makes at the beginning of a patient initiated consultation - will be direct and succinct.

How does the dentist respond to a patient's report? It was found that in all cases, whether the report was presented directly in a continuing treatment consultation, or indirectly in a patient initiated consultation, the dentist's response is likely to be muted or even non-existent. That is to say, the dentist (presumably) examines the patient for evidence of the complaint which is reported. However, he then frequently fails to report the result of this examination to the patient, particularly if it coincides with the patient's own interpretation. But when the dentist's diagnosis does not coincide with the patient's own report (even if the disagreement is only one of degree) the dentist is likely to draw attention to the inaccuracy of the patient's report. Thus the dentist characteristically minimises the accuracy of a patient's description of his symptoms, and may also delay his response or even avoid responding altogether; but on the other hand he emphasises any inaccuracy contained in the patient's report.

These observations concerning the ways in which patients report new symptoms to their dentists and the ways in which dentists react to such reports may be thought of as rules of discourse. That is to say, the observed phenomena may be described in terms of rules in so far as this behaviour is repeatedly and predictably seen amongst patients and dentists. Descriptive (rather than prescriptive) rules of communication can, therefore, be drawn up for this one limited area of dentist-patient discourse. This in turn means that the basic requirement for a discrete point test has been satisfied.

It is possible now to judge what behaviour is appropriate, what is inappropriate, and why this should be so. The criteria for evaluation - at least in this one very small area - now exist.

But at this point problems arise. It has been argued (Candlin, Burton and Coleman 1980) that one of the most conspicuous characteristics of patient attitudes to the dental consultation is that patients feel strongly that they are granted no opportunity to speak during the consultation. It has also been shown that in fact patients do have consdierable opportunity to speak during the consultation. However, this opportunity is constrained by the rules of discourse which have been described earlier in this section. In consequence, patients generally are relatively free to discuss matters not related to their symptoms, but are relatively restricted when discussing symptoms. The outcome is that patients experience frustration when attempting to discuss the matter which, for them in that situation, is of primary importance, and this sense of frustration dominates the patient's retrospective impression of the whole consultation. It cannot be compensated for by freedom to talk about matters which are essentially peripheral.

From the dentist's point of view, on the other hand, it is important that he should maintain control of the consultation, whilst making the minimal number of concessions required to ensure cooperation from the patient. (Although to some extent discussed in Candlin, Burton and Coleman (op. cit.), this is not an aspect which has been adequately investiagted yet.

The problem, then, for the test designer is that there may be three alternative approaches to discoursal features of the type which we have been

discussing. At one extreme there is behaviour which is ideally suitable for the patient : the dentist gives adequate opportunity for the patient to describe new symptoms, listens attentively to the patient's report, comments constructively on the patient's self-diagnosis, compliments the patient when his self-diagnosis is reasonably accurate, and minimises or ignores any irrelevance or inaccuracy in the patient's report. This sort of behaviour would avoid frustration on the patient's part, but it would be time consuming and inefficient for the dentist. At the other extreme there is behaviour which is ideally suitable for the dentist : the patient speaks only when spoken to, and provides clear unambiguous information about the precise nature of his symptom and its location, thus enabling the dentist to work efficiently and without unnecessary interruption. This sort of behaviour would be intolerably frustrating for the patient. The third alternative is that which has been observed : an uneasy compromise between the dentist's need to work quickly and efficiently and the patient's need to be treated as an individual with attention paid to his own perceptions of his own complaints.

Which of these three types of behaviour is to be considered 'correct' in a testing situation? If an examinee-dentist displays highly sensitive behaviour towards his patients is he to be highly graded (even if, in practice, he may soon find himself approaching bankruptcy)? Or if the dentist displays efficient but insensitive behaviour is he to be highly graded? Or is the examinee-dentist to be highly graded only if he approximates to the norm established by the majority of dentists and patients in our society? (A parallel problem is encountered when language behaviour alone rather than communicative behaviour is being examined. Does one demand of the examinee linguistic perfection (i.e. 'native speaker plus'); or an approximation to

native speaker proficiency; or a third, lower level of proficiency which avoids conspicuously non-native features but which nevertheless falls short of native speaker proficiency (see also Alderson 1980 on this point). The solution to this problem is not easy and cannot be dogmatic. Arguably, by demanding the examinees approximate to native speaker ("native-communicator") behaviour, the test designer is reinforcing a status quo which may be inadequate or inappropriate for the patient and for the dentist himself. This problem can be stated, but for the moment must be left unanswered. An attempt to come to terms with it will be made later.

5 SIMULATIONS, ROLE PLAYS AND ANALYSIS OF OWN BEHAVIOUR

Burton (1980) has proposed a Language Proficiency Test for Dentists from Overseas (LPTDO). In this paper we have been arguing that linguistic features alone do not constitute a dentist's total communicative inventory. The objective of the test designer must, then, be to establish a viable format for a Communicative Proficiency Test for Dentists from Overseas (CPTDO), which will make use of the insignts provided by analyses of the type described in the preceding section.

Simulated medical consultations and role-play medical consultations have been used as teaching techniques and, occasionally, as testing techniques in medical education (for native speakers of English), particularly in the U.S.A. Werner and Schneider (1974) believe that one of the physician's tasks is to communicate effectively and interact with a patient :

> The degree to which interactions in the doctor-patient relationship can be systematically examined would make this aspect of clinical work similar to the process of using data to establish a diagnosis or treatment plan. Just as clinical judgment has been described as an examinable process, so have the data-gathering and hypothesis-generation aspects of the clinician's work. Although recognizing certain unique problems, we have viewed the interactions comprising the doctor-patient relationship as definable and subject to analysis. Therefore these interactions are teachable, as are other clinical skills.
>
> (p 1232)

This position is very close to the one which we have been arguing for throughout this paper. We might add, also, that interactional skills are not only definable, analysable and teachable, but also - like data gathering and hypothesis-generation - examinable.

The aim of the interactional skills course which Werner and Schneider

have developed is that student doctors should be able to recognize, describe and use a variety of responses in their interaction with patients. Student doctors are video-recorded as they interview real patients. The video-recordings are played back and critically analysed with constant reference to a theoretical base. As this process continues over a period of time students acquire a wider inventory of interactional skills and greater flexibility in making appropriate selections from that inventory.

A similar course is described by Secundy and Katz (1975). The objectives of the one semester elective for freshman and sophomore medical students, 'Factors in Patient-Doctor Communication', are that the students should develop abilities to interview patients with ease, that they should develop an awareness of the ways in which the doctor influences the patient's interaction, and that the students should expand their 'repertoire of alternative responses to patients'. The techniques employed are similar to those described by Werner and Schneider. Simulated interviews, in which the roles of both doctor and patient are played by drama students, are video-recorded, then shown to the medical students and analysed. At the next stage, the patient roles continue to be played by drama students, but the doctor roles are taken by the medical students. The consultations are, again, video-recorded and then discussed by the medical and drama students together. The 'patients' at this stage frequently complain that medical students have 'few emotional resources'. In the final stage, the medical students encounter real patients, the consultations are video-recorded and then played back to the students for self-assessment.

Santiesteban (1975) stresses that organizers of courses of this type must pre-determine the interviewing techniques which are to be presented as

models. These may include silence, probing, reinforcement and open-ended questions. A variety of patient types should also be presented :

> Variable patient response patterns can also be exhibited. The patient may be depressed, garrulous, shy, or angry. (p 637)

Students, however, remain passive and simply observe edited video-recordings of actual doctor-patient consultations, or video-recordings of simulated consultations in which the roles of both doctor and patient are played by actors.

The possibility of evaluating student performance is discussed by Levine and McGuire (1970) and by Rasche, Bernstein and Veenhuis (1974). The test of affective skills designed by Levine and McGuire requires the examinee to play the role of doctor in interaction with a 'patient' or a 'colleague' who is played by one of the examiners. A second examiner observes the consultation and evaluates it. Levine and McGuire conclude that :

> . . . the half-hour Simulation Oral, consisting of three or more standardized exercises, administered by two examiners, and independently scored on an objective type rating form, reached an acceptable level of reliability. (p 702)

Furthermore :

> . . . the role-playing simulations appeared to meet acceptable standards of content validity as samples of specified attitudes and skills in patient and colleague relations. (p 702)

Construct and concurrent validity, however, were less impressive :

> . . . the data are compatible with the assumption of reasonable construct validity of the Simulation Orals, but are by no means conclusive in establishing it. (p 703)

Evaluation of concurrent validity was made difficult by the problem of selecting "criteria to be employed in rating the affective components of professional competence" (p 705).

Rasche et al. (1974) identified five general types of student-doctor verbal response to patients in the medical interview : evaluative, hostile, reassuring, probing and understanding. A 'Physician-Patient Situation Test', administered before and after a course in interviewing techniques for medical students, showed that there was a significant increase in the number of understanding responses selected by students. An evaluation of actual student performance before and after the course revealed significant increases in the use of understanding and facilitative probing responses, and significant decreases in the use of evaluative and non-facilitative probing responses.

This survey of the training and testing of interview skills for native speaker medical students indicates that the evaluation of communicative skills is neither unknown nor impossible. Of particular interest is the observation by Werner and Schneider that definition and analysis precede teaching, and that teaching precedes examination, but that all four of these tasks are aspects of one process. Oller (1979) makes a comment which is remarkably similar :

> Merely requiring language tests (or other educational tests) to measure what the curriculum teaches may not be enough. It will be enough only if the curriculum teaches what it is supposed to teach. . . . there must be a deeper validity requirement. It must be more abstract, more profound, more fundamental than any particular curriculum. The ultimate validity criterion is not a mere requirement for tests alone, but it must be a requirement for the curriculum itself. . . . The ultimate criterion must be what people do when they use language for the purpose of communication.
>
> (p 404)

Let us at this point review what has been accomplished so far :

1 The General Medical Council's PLAB Test provides a model for one kind of language test for overseas dentists.

2 The validity of the PLAB Test is questionable in that it demands native speaker awareness and competence in doctors who are recently arrived in Britain and who may never have treated a British patient.

3 The PLAB Test's validity is also questionable in other ways : an unusual metalinguistic task is demanded of subjects in the modified essay question, whilst at least three of the four recorded sections are concerned with isolated features of language which in their own ways are as important or unimportant as features which have been examined in more traditional tests.

4 Pragmatic tests are not - yet - discrete point tests simply because the present state of knowledge concerning discoursal features is so poor. As more is learnt about discoursal structure so discrete points will become identifiable. But a test of communicative competence must, by definition, be a pragmatic test.

5 Certain descriptive 'rules' of dentist-patient communication have been enunciated.

6 These 'rules' forbid ideally sensitive and ideally efficient behaviour on the part of the dentist. Actual behaviour is a form of compromise between that which is most acceptable to the dentist and that which is most acceptable to the patient.

7 Attempts have frequently been made to develop and evaluate the communicative competence of native speaker medical students.

8 Simulations, role plays and video-recordings of real consultations have been found to be useful in the teaching and testing of interview techniques.

9 A close relationship exists between available descriptions of the ultimately desired behaviour, teaching and testing.

In the final section an attempt will be made to bring these nine points to bear in considering the design of a Communicative Proficiency Test for Dentists from Overseas.

6 A COMMUNICATIVE PROFICIENCY TEST FOR DENTISTS FROM OVERSEAS

It is proposed that the Communicative Proficiency Test for Dentists from Overseas be administered while the overseas dentist is experiencing a structured induction into life and dental practice in the United Kingdom, rather than at the moment he first arrives in Britain. The Overseas Doctors Association (Reference and Community Services 1976) proposed :

> . . . a three-month clinical attachment and assessment period in a district hospital, on 50% of a houseman's salary, and with access to language, training and clinical ward rounds.
>
> (p 24)

It is reasonable to assume that dentists would require a shorter induction period than doctors, though at this point it cannot be said what the optimum duration of such a period would be.

Throughout the period of clinical attachment and assessment - the induction period - the overseas dentist would be based at one of the seventeen dental teaching hospitals in Britain and Ireland (Central Office of Information 1977; p 52). One of the aims of the induction period would be to introduce the overseas dentist to the bureaucratic structure of the National Health Service, which would necessitate familiarity with the wide range of forms and standardised correspondence which he will be required to deal with. Another purpose would be to acquaint the overseas dentist with his legal rights and obligations as a practising dentist. This would require the dentist to be able - at least - to extract the gist of documents which constrain and stipulate those rights and obligations respectively.

However, the primary aim of the induction period would be to allow the overseas dentist to become familiar with the discoursal rules which apply in

dentist-patient encounters in our society, and, importantly, to enable the dentist to perceive the limitations which those rules imply (limitations on total dentist efficiency, limitations on total sensitivity towards the patient). The induction period should, then, be seen as a period during which the overseas dentist a) is taught, b) observes, c) participates, and d) is assessed. That is to say, the overseas dentist has the norms and inadequacies of dentist-patient communication in our culture brought to his attention. He then identifies instances of these behavioural features from real data. He encounters patients in the context of consultations and attempts to approximate his own behaviour to those norms. Finally, the dentist's awareness of ideal, normal and inappropriate features of behaviour is measured, and his own success in moving towards appropriate behaviour is evaluated. These four tasks must not be considered as discrete consecutive stages, but, rather, as aspects of an integrated process which continues for the duration of the induction period.

An example of how this might be achieved follows. The overseas dentist observes (via a video-recording) a real consultation in which a continuing patient enters the surgery, and is asked to sit down. The dentist reviews the treatment programme in which he and the patient are engaged, but he grants the patient no opportunity to report on the present state of his dental health. Some time after treatment work has commenced, the dentist asks, "Not had any trouble with that one we filled last time, have you?" The patient immediately responds, "No, but this one here's been troubling me." The dentist makes no verbal response, examines the tooth which the patient is complaining of and, in silence, makes his diagnosis. Towards the end of the consultation the dentist announces, "Make an appointment with the receptionist for next week,

will you? Then we can have a look at that one at the back there." The overseas dentist and the induction period supervisor analyse and discuss the consultation, the techniques employed by both dentist and patient, and the advantages and disadvantages associated with these techniques. Right from this initial stage the induction period supervisor evaluates the overseas dentist's perspicacity in performing the analysis.

Later, the overseas dentist encounters patients in consultation. His performance is video-recorded and then, in the same way, is discussed and analaysed with the induction period supervisor, with attention being given only to those discoursal features which have already been discussed in the earlier session.

As the induction period progresses the complete inventory of features of dentist-patient communication is analysed, and the dentist is put into situations (simulated or real) in which it would be appropriate for him to employ those features. Inevitably, however, those features which have been discussed on previous occasions during the induction period reoccur, or situations in which it would be appropriate to employ those features reoccur. This allows the induction period supervisor to make a continuous assessment of the overseas dentist's maintained sensitivity towards and use of those earlier features. In other words, the overseas dentist's behaviour towards the end of the induction period can be compared with his behaviour when the induction period began.

It is, therefore, proposed that the communicative competence of overseas dentists be evaluated through a process of continuous assessment which is integrated into an induction period.

It is believed that the adoption of this procedure would satisfy the nine points made in this paper and summarised at the end of Section 5 above. Reliability of the procedure could be ensured by employing two or three induction period supervisors.

Our proposal, then, is not that the evaluation of the communicative proficiency of overseas dentists be undertaken in the format of a conventional test, but that it should be integrated with an induction course in which discrete features of normal dentist-patient communication are presented 'pragmatically', in context.

A postscript might be added to the effect that considerable work remains to be done before an induction programme can be designed in detail. Most urgently, work is needed to prepare as complete a taxonomy as possible of the rules of dentist-patient discourse. The set of rules described in Section 4 above covers only one very small area : the remainder is unexplored.

BIBLIOGRAPHY

ALDERSON, J. Charles 1980

Native and Nonnative Speaker Performance on Cloze Tests. Language Learning, vol. 30, no. 1. 1980. pp 59 -76

ALDERSON, Dick and WARD, Vivienne 1979a

English Tests for Doctors: Student's Book. Sunbury-on-Thames, Nelson, 1979.

ALDERSON, Dick and WARD, Vivienne 1979b

English Tests for Doctors: Answers and Teacher's Notes. Sunbury-on-Thames, Nelson, 1979.

ALLEN, J.P.B. and DAVIES, Alan (eds) 1977

Testsing and Experimental Methods. London, Oxford University Press, 1977. The Edinburgh Course in Applied Linguistics, vol. 4.

BOWEN, J. Donald 1976

Current Research on an Integrative Test of English Grammar. RELC Journal, vol. 7, no. 2. December, 1976. pp 30 - 37.

BOWEN, J. Donald 1977

The Integrative Grammar Test: A Further Note. RELC Journal, vol. 8, no. 2. December, 1977. pp 94f.

BURTON, Jill I. 1980

Proposals for a Language Proficiency Test for Dentists from Overseas. Lancaster, M.A. Research Design in Language Learning and Testing Project, 1980.

CANDLIN, Christopher N., BURTON, Jill I. and COLEMAN, Hywel 1980

Dentist-Patient Communication: A Report to the General Dental Council. Lancaster, Department of Linguistics and Modern English Language and Institute for English Language Education. 1980.

CENTRAL OFFICE OF INFORMATION 1977

Health Services in Britain. London, HMSO, 1977. 9th edition. Central Office of Information Reference Pamphlet, 20.

COLEMAN, Hywel 1977

The Integrative Grammar Test: A Comment. RELC Journal, vol. 8, no 2. December 1977. pp 91 - 93.

DAVIES, Alan 1977

The Construction of Language Tests. Allen, J.P.B. and Davies, Alan (eds) Testing and Experimental Methods. London, Oxford University Press, 1977. pp 38 - 104

LADO, Robert 1961

Language Testing: The Construction and Use of Foreign Language Tests: A Teacher's Book. London. Longman, 1961.

LEVINE, Harold G., M.P.A. and McGUIRE, Christine H., M.A. 1970

The Use of Role-Playing to Evaluate Affective Skills in Medicine. Journal of Medical Education, vol. 45, no. 9. September 1970. pp 700 - 705.

OLLER, John W., Jr. 1979

Language Tests at School: A Pragmatic Approach. London, Longman, 1979. Applied Linguistics and Language Study Series.

PROFESSIONAL AND LINGUISTIC ASSESSMENTS BOARD 1980

Notes for the Guidance of Examiners. Cyclostyled document. May 1980.

RASCHE, Lois M., Ph.D., BERNSTEIN, Lewis, Ph.D., and VEENHUIS Philip E., M.D. 1974

Evaluation of a Systematic Approach to Teaching Interviewing. Journal of Medical Education, vol. 49, no. 6. June 1974. pp 589 - 595

REA, Pauline 1978

Testing Doctors' Written Communicative Competence: An Experimental Technique in the Testing of Writing Proficiency in English for Specialist Purposes. Institute for English Language Education, University of Lancaster, unpublished paper. May 1978. (Originally presented at a meeting of the University of Lancaster Linguistics Circle, November 1976.)

REFERENCE AND COMMUNITY SERVICES 1976

Doctors from overseas: A Case for Consultation. London, Community Relation Commission, June 1976. Reference Series, no. 9.

SANTIESTEBAN, A. Joseph 1975

The Use of Psychological Models in Medical Education. Journal of Medical Education, vol. 50, no. 6. June 1975. pp. 636 - 637.

SECUNDY, Mariam G. and KATZ, Vera 1975

Factors in Patient-Doctor Communication: A Communication Skills Elective. Journal of Medical Education, vol. 50, no. 7. July 1975. pp 689 - 691.

WERNER, Arnold, M.D. and SCHNEIDER, John M., Ph.D. 1974

Teaching Medical Students Interactional Skills: A Research-Based Course in the Doctor-Patient Relationship. The New England Journal of Medicine, vol. 290, no. 22. 30 May 1974. pp 1232 - 1237.